Workers' Compensation/No Fault Disability Questionnaire: Please answer all questions completely. The information is used for your Workers' Compensation or No Fault Claim Forms. Any incomplete or incorrect information may lead to a delay in your claim.

Patient's Name: _____ Today's Date: _____

Insurance Company: _____ Date of Injury: _____ Claim #: _____

Have you had a recent IME (Exam from Insurance Company Physician)? YES NO Date: _____

Have there been any changes to your case since your last visit? YES NO

If YES, please specify: _____

Are you currently employed? YES NO **Are you currently working? YES NO**

If **YES**, are you working?____Full Time ____Part Time ____Full Duty ____Light Duty

If **YES**, do you have any of the following restrictions?

- Bending/Twisting
- Climbing Stairs/ Ladders
- Environmental Conditions
- Kneeling
- Lifting
- Operating Heavy Equipment
- Other: _____
- Operation of Motor Vehicle
- Personal Protective Equipment
- Sitting
- Standing
- Use of Public Transportation
- Use of Upper Extremities

If **NO**, when did you stop working? _____ Did you stop working as a result of the injury? YES NO

When do you plan to return to work? _____

I hereby certify the statements hereon and attached are completed and accurate and I authorize any person or institute rendering care or any person or organization in possession of insurance or other benefit information concerning me to furnish or disclose all known facts concerning this disability. A copy of this authorization shall be valid as the original.

Patient's Signature _____